MISSOURI

DIVISION OF MEDICAL SERVICES

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Pharmacy Bulletin

Due to budget constraints, paper copies of bulletins will no longer be distributed by DMS. Bulletins are now available only at the DMS Website.

Bulletins will remain on this site only until incorporated into the provider manuals as appropriate, then deleted.

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MC+ MANAGED CARE

The information contained in this bulletin applies to coverage by the MC+ fee-for-service and Medicaid fee-for-service programs. The MC+ fee-for-service and Medicaid fee-for-service programs also provide coverage for those services carved out of the MC+ Managed Care benefit for MC+ Managed Care enrollees. Questions regarding services included in the MC+ Managed Care benefit should be directed to the enrollee's MC+ Managed Care health plan. Please check the patient's eligibility status prior to delivering a service.

CHANGES IN PHARMACY BILLING

In order to comply with the Health Insurance Portability and Accountability Act (HIPAA) mandatory standards, effective October 16, 2003, the Missouri Medicaid pharmacy program will

be implementing NCPDP version 5.1 for all Point-of-Sale (POS) pharmacy claims billing. Pharmacy providers wishing to exchange electronic transactions with Missouri Medicaid may now view the NCPDP Telecommunication V.5.1 and Batch Transaction Standard V.1.1 Companion Guide on Missouri Medicaid's web page at www.medicaid.state.mo.us. To access the Companion Guide, select Missouri Medicaid Electronic Billing Layout Manuals; select Systems Manuals; select electronic claims layout; select NCPDP Telecommunications V.5.1 and Batch Transaction Standard V.1.1 Companion Guide. For information on Trading Partner Agreements, select Section 1 – Getting Started; select Trading Partner Registration. All questions concerning Trading Partner Agreements or provider testing schedules should be directed to the Verizon Help Desk at 573-635-3559.

Due to this software upgrade, pharmacy providers will notice the following changes in claims processing.

DECIMAL QUANTITY

Currently, when dispensing products whose metric quantity includes a decimal, providers are required to round to the next whole number. For POS claims submitted using NCPDP version 5.1 software, a new field will be added that will allow for the actual decimal quantity to be billed. The decimal quantity field will have a character field length of 9,999,999.999. Providers must bill the actual decimal quantity dispensed in this field, rather than rounding to the next whole number. The metric quantity field will still be used on drug claims that are not submitted using the new version 5.1 software (i.e. paper claims and internet claim submissions) and will therefore, still need to be rounded.

CLARIFICATION FOR DECIMAL QUANTITY MEDICATIONS

POS billing of medications with a decimal in the quantity must be calculated as follows:

- Containers of medication in solution (for example, ampules, bags, bottles, multi-dose vials) must be billed by milliliter (ml) dispensed, even if the quantity includes a decimal. (i.e., if three (3) 0.5 ml vials are dispensed, the correct quantity to bill would be 1.5 mls)
- Containers of injectable medications that require reconstitution (powder filled vials) must be billed by the number of vials. (The exception to the rule is the product Herceptin, by Genentech, which must be billed by milligram, even though it is a powder filled vial.)
- Single dose syringes and single dose vials must be billed per milliliter (ml), rather than per syringe or per vial.
- Immunizations must be billed by the milliliters (mls) dispensed, rather than per dose.
- Packages consisting of more than one container, designed to be used together, are to be billed as a kit (one kit = one billing unit).
- Ointments must be billed per number of grams even if the quantity includes a decimal.
- Eye drops must be billed per number of milliliters (mls) in each bottle even if the quantity includes a decimal.

PARTIAL FILLS

For POS and batch claims submitted using NCPDP version 5.1 software, a new field will be added to properly identify partial fills. The values for this new field will be 'P' for partial fill and 'C' for complete fill. In instances where the initial claim is a partial fill ('P'), providers should bill the

completion of the prescription ('C') using the same prescription number. The partial fill script will have appropriate copay and dispensing fees applied. The completion claim will not. This field does not appear on paper claim or Internet claim submissions.

COMPOUNDS

For POS and batch claim submissions using NCPDP version 5.1 software, pharmacies will be able to bill compound claims with up to 25 ingredients. Although billed as one claim, the multiple ingredients of a compound will appear as separate lines on the Remittance Advice and will have a common prescription number. The first ingredient billed will be assigned a compound indicator of '2' and will have copay and dispensing fees applied. All remaining ingredients will be assigned a compound indicator of '1' and will not have copays or dispensing fees applied. Compounds billed with 4 or fewer ingredients will be adjudicated on-line. Compounds billed with 5 or more ingredients will not be processed in real time, but will be captured and processed in batch. Paper claim and Internet claim submissions will continue to be manually priced as they are now.

MEDICAID SPECIFIC CODES

To prepare for the mandatory implementation of HIPAA standards, DMS has replaced many state specific level III codes. HIPAA mandates that states allow providers to bill for services using the standard code sets. As a result, local Medicaid specific codes will no longer be accepted as the NDC number or the billing procedure code for claims submitted to Missouri Medicaid. Claims for compounds, over-the-counter drug products, exception approvals, durable medical equipment (DME) and home health services, will require the actual NDC number or procedure code for a valid claim submission. Continued use of the local codes after October 16, 2003, will result in claim denial.

EXCEPTIONS PROCESS PLANNED BILLING CHANGES

The following information pertains to changes that will take effect late 2003 or early in 2004. A definite implementation date cannot be provided at this time.

Once system programming is completed The Exceptions Process will no longer use local Medicaid specific codes (primarily DME and some nursing services) to manually price and pay for Medicaid services approved for payment through the Exceptions Process. Providers will be required to submit claims with an invoice of cost (when required) for the approved services along with the HCPCS code available that most accurately describes the item of service. The level of care modifier 'UB' must be included to identify the item or service as an Exceptions Process Service. These items will continue to be manually priced by DMS staff. Pricing structure will be consistent with covered DME program items for which there is an established fee schedule. Claims submitted for items approved by the Exceptions Process will now be accepted electronically as well as by paper claims. Once an Exceptions claim has been electronically submitted, any required attachments to the claim, such as invoice of cost, will need to be mailed to the address listed below. A routing sheet will be required to accompany the attachment so that it can be properly matched to the electronically submitted claim. This routing sheet is available for download on the Missouri Medicaid website at www.dss.state.mo.us/dms. Go to "Shortcut to list of forms," and the document will be titled "837/NCPDP Required Documentation (RD) Routing Sheet." A separate 837/NCPDP RD Routing sheet must be completed for each claim requiring an attachment. Claims submitted

electronically will hold for a period of 45 days in waiting for the required attachment to be received and matched to the claim. If after those 45 days the attachment has not been received, the claim will automatically deny without manual review.

Providers should note the following address change for paper claims submissions and attachments for electronic claims submissions to the Exception Process:

Verizon
P.O. Box 5800
Jefferson City, MO 65102

INTERNET PHARMACY CLAIM

The following field names and corresponding values on the Internet pharmacy claim form will be changed to:

Field #5, Nursing Home to Patient Location.
Field #6, EPSDT to Prior Authorization Type Code.
Field #7, Other Insurance to Other Coverage Code.
Field #12, Refill Code to Fill Number.

A new field will be added on the Internet Pharmacy Claim Form to be named Unit Dose Indicator.

NCPDP BATCH STANDARD VERSION 1.1

In addition to the NCPDP version 5.1, we will also support NCPDP Batch Standard Version 1.1 for all batch processing and especially large transmissions. Version 1.1 will not be adjudicated real time.

REBILLS AND REVERSALS

A new option will be available under version 5.1 allowing POS claims to be rebilled. A rebill will include both a reversal and the rebilling of a claim in a single transaction. Up to 4 claims will be allowed per transmission.

Reversals for credit only (as opposed to rebills) will also allow up to 4 claims per transmission.

REVERSAL TIME EXPANSION

Effective July 14, 2003, the period of time in which providers may reverse a POS pharmacy claim was increased from 7 to 45 days. This change allowed providers to reverse a claim up to 45 days after the claim was filed. For example, starting on July 14, a provider could reverse a claim that was filed on date of service May 30, 2003 or after.

The Division of Medical Services has implemented this change to assist providers in reversing claims as needed. This change is expected to decrease the number of manual claims adjustments currently required.

CHANGE IN REIMBURSEMENT FIELDS

Effective July 26, 2003, POS version 3.2/3.C and version 1.0 included a breakdown of the aggregate reimbursement into ingredient cost and dispensing fee. This information is displayed in the following fields for BOTH versions:

- Allowed Charge – NCPDP name is Ingredient Cost Paid, and the field number is 506.
- Dispensing Fee – NCPDP name is Contract Fee Paid, and the field number is 507.

CONTINUED PHARMACY PROGRAM CLINICAL ENHANCEMENTS

The Missouri Medicaid Pharmacy Program continues to implement administrative and clinical edits to ensure economic and efficient provision of the Medicaid pharmacy benefit. Using predetermined standards; POS pharmacy claims are being routed through an automated computer system to review drug therapies to screen each claim prior to payment. These edits are based on evidence-based clinical criteria and available nationally recognized peer-reviewed information. The current proposed edit implementation schedule (Attachment A) is available on our website at www.dss.state.mo.us/dms.

DEA NUMBERS

Effective May 15, 2003, Missouri Medicaid allows the use of the prescribing physician's DEA number in the prescriber identification field. In addition, providers are also able to utilize the Missouri Medicaid provider number, or the state abbreviation and seven-digit phone number for out of state prescribers. It is the responsibility of each provider to ensure the accuracy of the prescribing physician's data on all claims submitted to the Medicaid program. As noted in past Bulletins, use of an inaccurate or false provider identification number may result in recouped claims and/or allegations of fraudulent activity.

PREPAYMENT REVIEW

Due to the high number of unit billing errors submitted by providers, effective July 31, 2003, the Missouri Medicaid Pharmacy Program placed the following drug products on prepayment review:

Drug	Manufacturer
Neupogen	Amgen
Neulasta	Amgen
Epogen	Amgen
Aranesp	Amgen
Copaxone	Teva
Procrit	Ortho

Prepayment review is a process by which all claims for these products will be reviewed for accuracy prior to payments being processed. Submissions of claims for these products follow all normal procedures; however the claim will not immediately pay at Point-of-Sale (POS). Instead these claims will post as "captured" until reviewed, if the claim is accurate, payment will then be processed. Providers can expect an approximate 2 to 4 day delay in payment processing for these claims. For specific questions concerning these drug products and their claims payment status, contact the Pharmacy Administration Unit, at (573) 751-6963.

CLAIM INTEGRITY FOR PHARMACY PROVIDERS

It is the responsibility of each provider to ensure the accuracy of all data on claims submitted to the Medicaid program, regardless of the media utilized. As provided in 13 CSR 70.3.030, sanctions may be imposed against a provider for failure to take reasonable measures to review claims for accuracy. One example is failure to review Healthcare Claim Payment Advices (remittance advices) provided for claims that results in payments that do not correspond to the actual services rendered. Billing errors including but not limited to incorrect ingredient indicators, quantities, days supply, prescriber identification, dates of service and usual and customary charges, caused or committed by the provider or their employees are subject to adjustment.

ATTACHMENT A

ADMINISTRATIVE and CLINICAL EDITS

Clinical edits are designed to enhance patient care and optimize the use of program funds through therapeutically prudent use of pharmaceuticals. Point-of-service pharmacy claims will be routed through an automated computer system to apply edits specifically designed to assure effective drug utilization. The edits are based on evidence-based clinical criteria and available nationally recognized peer-reviewed information. Through the clinical edit process therapy will automatically and transparently be approved for those patients who meet any of the system approval criteria. For those patients who do not meet the system approval criteria, therapy will require a call to the Medicaid Drug Prior Authorization hotline at (800) 392-8030 to initiate a review and potentially authorize claims.

Clinical Edits Implemented	Effective Date
Zelnorm	08/07/2002
Vfend	09/25/2002
Geodon Injectable	10/25/2002
Dienestrol Powder	11/18/2002
Hydroxyprogesterone Caproate Powder	11/18/2002
Oxandrin 10 mg Tablets	11/25/2002
Cox-2 Inhibitors	12/16/2002
Zetia	12/30/2003
Forteo	01/27/2003
Strattera	02/10/2003
Cipro XR	02/17/2003
HMG-CO A Reductase Inhibitors	02/18/2003
Non-Sedating Antihistamines	02/26/2003
ACE Inhibitors	03/12/2003
Actiq	03/26/2003
Synagis	05/14/2003
Duragesic	05/14/2003
Alinia	05/14/2003
Suboxone/Subutrex	05/14/2003
Oxycontin	05/24/2003
Emend	05/28/2003
Thalomid	05/28/2003
H2 Antagonists Step Therapy	06/18/2003
Klonopin Wafers	07/15/2003
Zometa	07/22/2003
Tramadol	07/23/2003
Dolgic LQ	08/01/2003

Scheduled Clinical Edits	Effective Date
Stimulants	08/27/2003
Zovirax Cream	09/03/2003
Xanax XR	09/10/2003
Carafate	09/24/2003
Lactulose	09/24/2003
Synagis	10/01/2003
Antibiotic Ready-To-Use Packs	10/15/2003
Diflucan 150mg Tabs	10/29/2003
Cold Sore Treatment Step Therapy	11/12/2003
Ophthalmic Antibiotic Step Therapy	11/19/2003